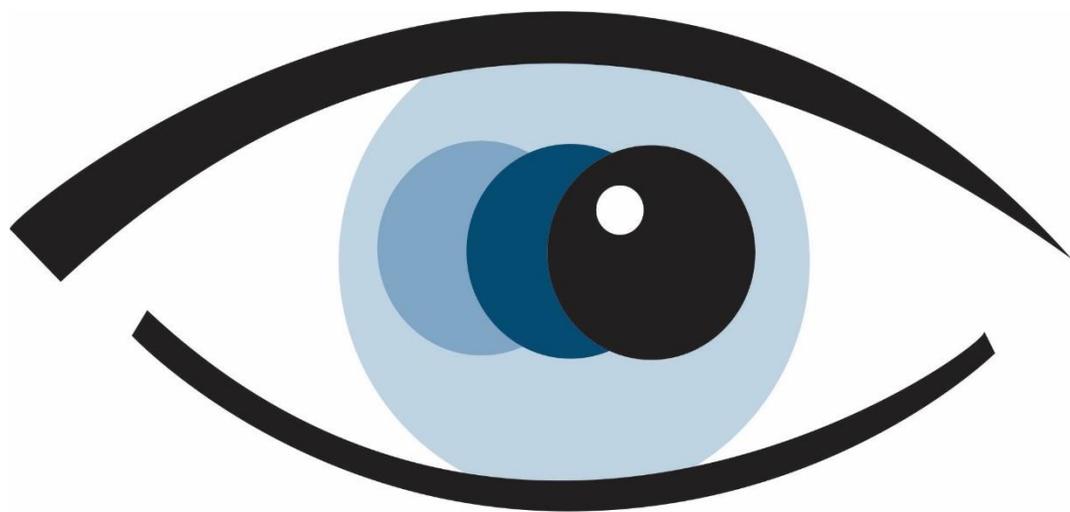


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Navigating Health Insurance

MAKING THE MOST OF YOUR HEALTH PLAN



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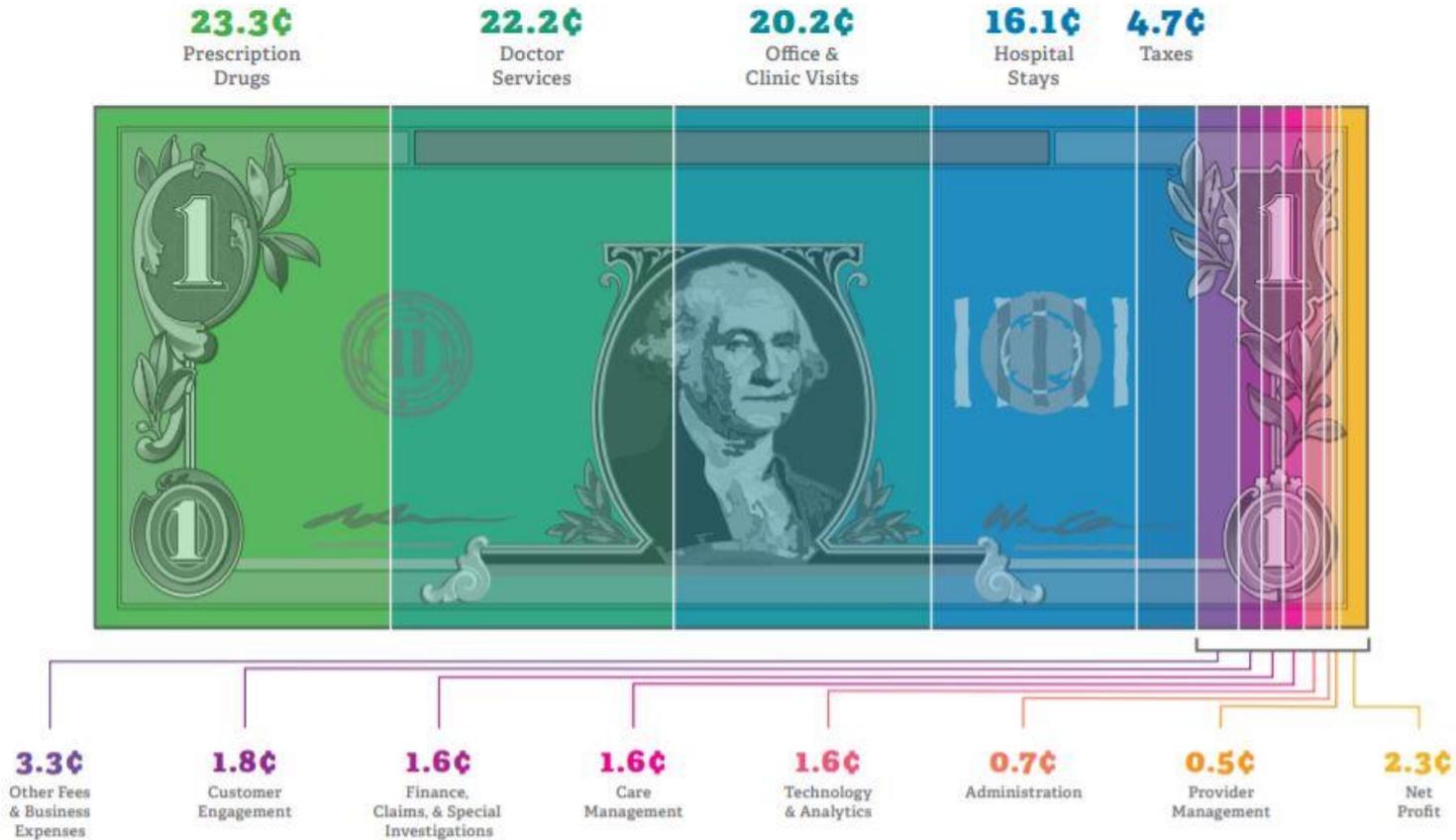
Understanding the basics

Know your plan.

**This deck was created to assist ANN members with general use of health insurance. Not all health insurance is the same, and to ensure you understand your plan specifics please consult your benefit paperwork and health plan directly. Any government and regulatory questions should be sent to the appropriate agency.*

Where Does Your Health Care Dollar Go?

Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive. It also helps to improve health care quality and affordability for all Americans. Here is where your health care dollar really goes.



Expenditure estimates above produced by AHIP. Distribution of spending among administrative categories and taxes, based on analysis by Milliman, Inc. Milliman's analysis is available upon request.

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Health Insurance Premiums



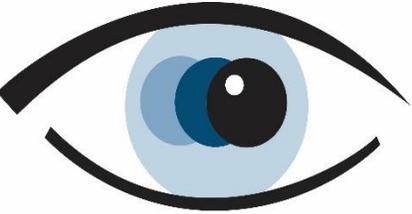
What is a premium?

An insurance premium is the installment fee that an individual or company must pay for the health insurance policy.



What are premiums used for?

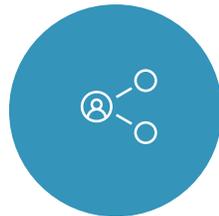
Premiums are used to cover the costs of health insurance. Health insurance companies pay for the health care you receive – including doctor visits, procedures, pharmaceuticals, wellness programs, and customer service.



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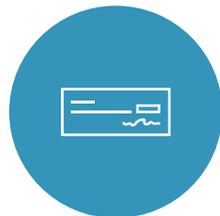
Does my premium cover the total cost for my health care?

No, not usually. Most health insurance policies include additional costs aside from what you or your employer/agency pay for the policy.



Deductible

Many insurance plans require a deductible to keep premiums lower. A deductible is a fixed out-of-pocket threshold per policy that must be met before the insurance policy starts coverage of health care costs. There can be multiple deductibles per policy, usually based on providers who do and do not accept your health insurance; or separated for pharmacy and medical expenses. Once a deductible is met, you may have to pay copayments and/or coinsurance.



Coinsurance

Coinsurance is a cost-sharing arrangement with the policy members and the health insurance company. Coinsurance is set at a percentage of care for certain services and usually applies once a deductible has been met. For example, a policy may be 90/10 where the cost of your care would be covered up to 90% by the health plan leaving you with a 10% cost share.

Coinsurance is usually billed to you later by your provider.



Copayment

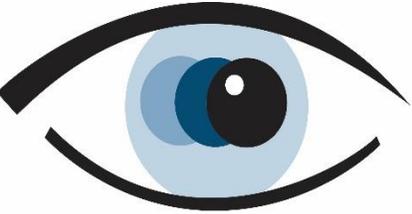
A copayment is a fixed out of pocket cost for specific health care services. Copayments rarely change in dollar amount throughout the lifecycle of policy. For example, you may have a \$20 copay for a physician visit, or a \$100 copay for an inpatient hospital stay.

Copays are often times due at your provider visit.



Out of Pocket Maximum

Your cost for health care should never go above the out-of-pocket max on your policy. Deductibles, copayments, and coinsurance all apply up to a certain dollar amount, once that amount is reached the health insurance company will pay 100% of your covered health care.



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Are all insurance plans the same?

No. Not only are all insurance policies different, but benefits can be different among the same plan types. Overarching plans typically fall within one of the categories to the right, although hybrid plans are becoming more popular.

It is important to ask your employer or plan administrator for support in navigating your options.

Plan Types

HMO

Health Maintenance Organizations will have copays, require members to seek care from a selected PCP, and only utilize in-network providers

PPO

Preferred Provider Organizations will typically have coinsurance and have access to out-of-network providers

EPO

Exclusive Provider Organizations are like an HMO in that in-network providers are required, plans could be copay or coinsurance based

POS

Point of Service plans will have copays for in-network care, with deductibles and/or coinsurance for out-of-network care

ASO

Administrative Services Only arrangements occur when employers want to take on full risk for the health care their employees receive. Insurance companies administer benefits as dictated by the employer.

High Deductible (HD)

Aside from HMOs, a plan type could also be High Deductible. These plans would have a lower premium, with a higher per service expense until the gap or deductible is met. Examples: HDPPPO, HDEPO



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What is a funding account?

An account used to supplement the costs of health care.

There are a few options available, but when an account can be used and what qualifying expenses are can be very complex to understand. At a very high-level, this chart explains ownership and use of each account type.

In some scenarios, you may have more than one of these accounts at one time. It is important to know when and how you can use each.

Ask your employer or plan administrator for support in navigating your options.

Funding Accounts

HSA

Health Savings Accounts are true savings accounts, owned and managed by the individual. Accounts must be used for health expenses and are pre-tax contributions. There are maximum annual contributions, but these accounts are long lasting and remain with the individual. These dollars can be saved to pay for health insurance post-retirement.

HRA

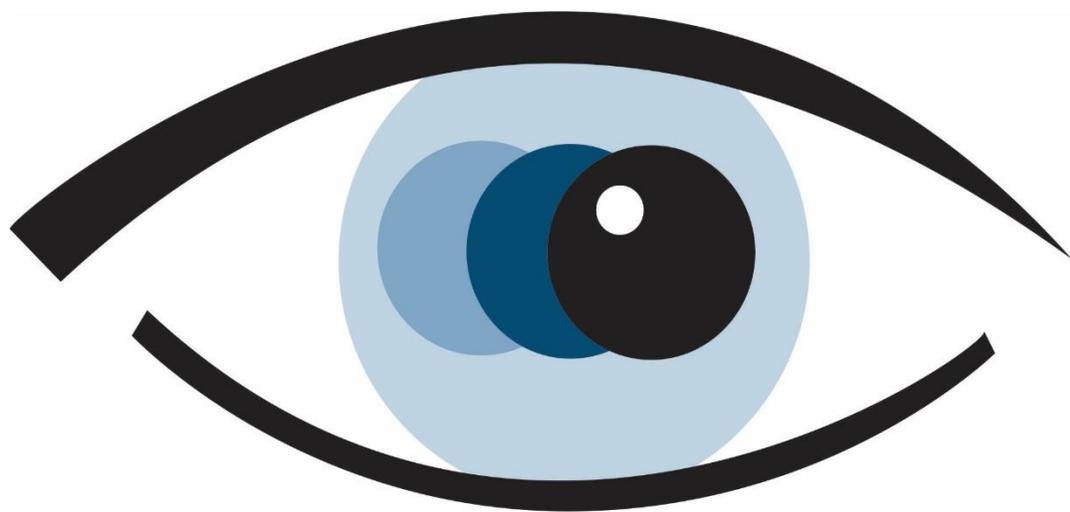
Health Reimbursement Accounts are spending accounts established by and owned by the employer, not the employee. The dollars in these accounts must be used for qualified health expenses, such as medical, dental, prescription, and vision as established by the employer. An employer may opt to offer a High Deductible plan and may supplement a portion of the deductible by giving the employee an HRA to use on certain expenses. The employer also sets annual rollover limits and once the employment relationship is terminated, these dollars are no longer accessible by the employee.

FSA

Flexible Spending Accounts or Flex Accounts are typically available in two variations: health and dependent care. A dependent care account is different than health and can be used for childcare expenses. These accounts are set up by and owned by the individual, employers may contribute but do not have to for the account to be used. FSA accounts follow a "use it or lose it" model and qualified expenses are regulated by the IRS. The health flex account can be used to pay for medical cost-share, drugs, contact lenses, and other health related expenses. There is a nuance to be aware of - an FSA could be either general or limited-purpose. You may also be able to rollover some funds from year to year, consult IRS documentations for most current regulation and allowances.

State and Federal Plan Offerings

It is important to check with your individual state to better understand the options available to you for state run programs. There are many variations in plan options and each state adopts a unique model. If you need assistance determining how to reach out to your local agency, please send an inquiry to the ANN Inquiry mailbox and someone will be happy to assist.



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Benefit Factors

Know how to use your plan.

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Do all policies offer the same benefits?

No. Plans are generally very customizable when purchased by an employer and tailored to the coverage they want to offer their employees; and much less so when purchased by an individual or agency.

In addition, state and federal agencies regulate certain plan types and have strict requirements over those policies.

Benefit Factors

The next few slides will cover information on the items below which all impact the benefits of your plan. Knowing what they are, how to navigate them, and how they change your benefit is key in using your plan.

- Provider Networks
- Diagnoses
- Prior Authorization – Utilization Management
- Benefit coverage maximums
- Other services:
 - Telemedicine
 - Wellness Programs
 - Care Management





Can a provider be both in and out of network with my insurance company?

Yes! Depending on the terms of their contract with the insurance company, a provider may only agree to service certain lines of business. The best way to know is to use the insurance company Provider Search and put your specific plan type into the tool, or to call your insurance company directly.

Provider Network

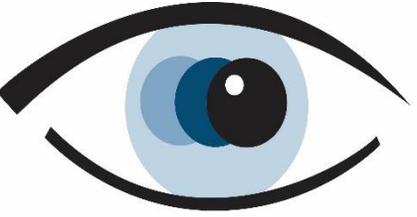
In – Network

- A provider who has a contract with the health plan and considers the schedule of fees within the contract as payment in full for their services
- Cost share for deductibles are based on the contractual amount and not what the provider charges for services, you only owe a cost share based on your benefit and cannot be billed more than that by the provider

Example	Provider Billed Charges	Contracted Amount (Allowed Amount)	Cost Share is Coinsurance at 20%
Eye Doctor Visit	\$725.16	\$198.00	$\$198 \times 20\% = \39.60

Out – of – Network

- A provider who does not have a contract with the health plan for your line of business
- The provider is not obligated to accept the payment in full and can balance bill you for services rendered
 - In the example above, that might mean you would owe your cost share – but may also owe the balance of \$566.76



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Is my cost share impacted by the diagnoses billed by my provider?

Yes, it can be! Payment policies are sometimes based on diagnosis. Preventative care is a great example of how diagnosis can drive payment of your insurance claims. Some states require preventative care (annual wellness visits, colonoscopies, mammograms, etc.) to be covered in full – if the coders billing the claim do not include the preventative diagnosis, you may be charged more for the service.

Diagnoses

Provider billing guidelines are complex to say the least. CMS and states have issued complex regulatory requirements and payment structures for services, sometimes driven the **diagnosis codes** billed by the provider.

A visit to your Primary Care doctor might have different cost share amounts based on the associated diagnosis. If it is coded by the provider billing office as being an annual physical, for most plans your visit should be free. If it is coded for a sinus infection, you might have a cost share. If it is coded for both, you may also have a cost share. The same would apply for other preventative services that can also be diagnostic in nature, like a colonoscopy.

Understanding this will better help you to navigate your care. If you think you are being overcharged for a cost-share, call your plan. They should be able to walk you through your claim and how the provider billed your services.



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How do I know if I need a Prior Authorization?

As a rule of thumb, you should call your health plan and ask. It is better to ask ahead of time and submit the correct paperwork, than to try to get something paid for when a service has been rendered without proper authorization.

Utilization Management

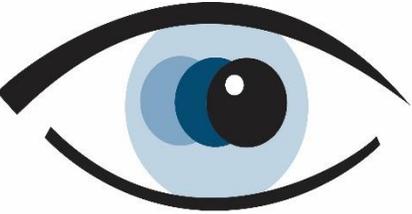
The Institute of Medicine defines Utilization Management as a “set of techniques used by or on behalf of purchasers of healthcare benefits to manage healthcare costs by influencing patient care decision-making through case-by-case assessment of the appropriateness of care prior to its provision.”

Medical Necessity Review

- For certain services, a health plan may require a medical necessity review to grant **Prior Approval** for the service to be considered covered by the plan. Reviews are based on clinical guidelines and best practices; and depending on your state requirements may be made available to you upon request.
- For example, a rhinoplasty can be cosmetic in nature, however, may be covered if your airways are constrained. More complex examples include surgeries like a tonsillectomy, which is likely covered outpatient based on minimal review, however if the provider is suggesting an inpatient stay that portion of the service may not be medically necessary depending on the patient.

Out-of-Network Care

- If your benefit structure does not cover access to out of network care, and you are looking to receive services from a provider who is not in network – you need to get an authorization to do so before the health plan will pay for your services. The only exceptions might be urgent and emergent care, **HOWEVER** know your plan before these situations arise.



Genetic Testing

Why isn't genetic testing covered by my plan?

**Please note ANN does not necessarily agree with the message below, but is sharing information from the POV of the plan*

Genetic testing is a hot button topic in healthcare. In some cases, genetic testing can change the entire trajectory of a care plan for an individual – but not all tests are created equal and not all conditions have tests that yield actionable results. If testing will not impact health outcome or change a care plan for an individual, then plans do not necessarily have to cover the cost. At that point, the results of the tests are considered more for personal knowledge than to truly impact or drive care.

This will likely be why some tests are covered and others are not.

For example, many plans cover some form of a BRCA test (breast cancer) with the right diagnoses or family history.

What might qualify me for genetic testing coverage?

- First, it may be wise to call your health plan to understand the guidelines used for clinical decision making surrounding genetic testing. Because this topic is so broad, they may not have the specific criteria used to approve for Nystagmus, but it is worth asking as it may help you and your provider determine if you qualify.
- Talk to your provider and the lab they intend to use to run the genetic tests. The lab may be able to guide you on the requirements to qualify for coverage and also complete any appeal paperwork should that be needed.

What else should I know?

It may be more cost effective to work with the lab directly. If your health plan doesn't approve care, or if you have a high deductible plan – it may be worth inquiring with the lab to see if they offer any direct pay options. They may offer a steep discount in order to help you get the test completed.



What are examples of service that may have a maximum allowable benefit?

Examples include dental, vision hardware, physical therapy, some durable medical equipment, and so on.

Benefit Coverage Maximum

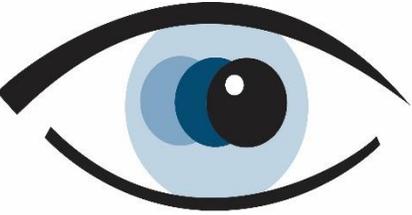
A maximum refers to a benefit limit – or the number of allowable units of a service – either on an annual or lifetime basis.

Annual limits are often applied to services such as therapies. An example might be that a person has 25 physical therapy visits allowed in a calendar or benefit plan year. It is important to know if your plan operates on **benefit year** (the date your plan is active plus 12 months) or **calendar year** (Jan-Dec). The clock would restart on the unit count once the 12 months reset.

You might also consider your annual wellness exam with your PCP or an OBGYN as a maximum. A plan may cover one visit without cost-share to an individual each year, knowing if your plan is benefit or calendar year can help you determine when you schedule your appointment for your next wellness visit to ensure it is covered without a cost to you.

Lifetime limits are applied to services such as durable medical equipment, or orthodontic work. Services with a limit are often considered non-essential. It is important to note that while a plan can cap certain non-essential services, under the Patient Protection and Affordable Care Acts they cannot cap their total expenditure on your healthcare.

Lifetime limits can also be a safeguard, particularly for those with high deductible plans. For example, health plans may watch for things like an appendectomy billed on an individual who had their appendix removed years prior. If these things weren't monitored, you could potentially pay a higher cost-share on a fraudulent claim.



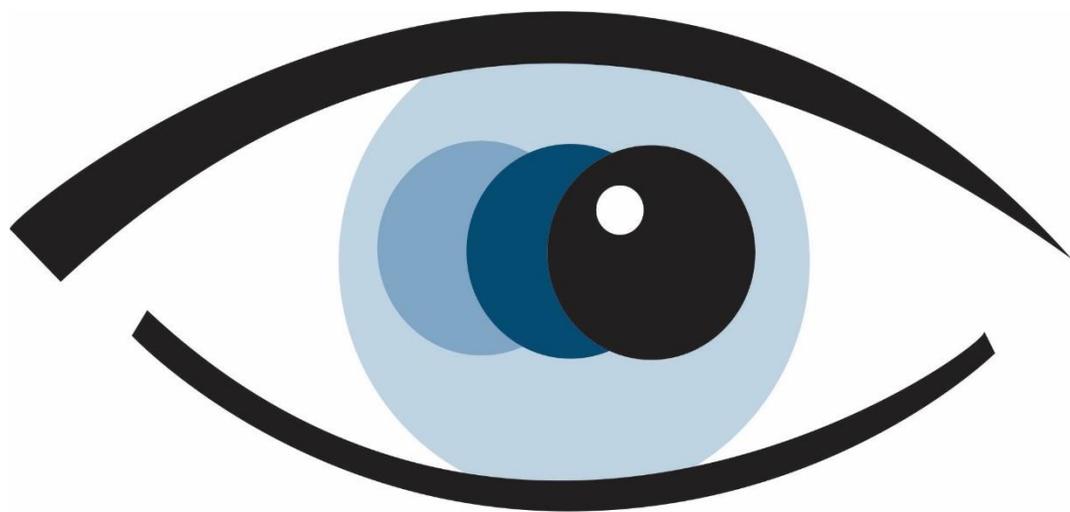
Other services offered by a health plan

Your health plan may offer additional services outside of typical health insurance coverage that can be of assistance in managing your health. It is beneficial to the health plan because people who use these services are often healthier and thereby cost less in the long run. A lot of these added offers can be great benefits and may also come with financial incentives for those who opt to use them.

Is there fine print for added benefits that I should know about?

Typically not. These extra or add-on benefits are to help people get into and maintain health and fitness. The benefit to the health plan is a cheaper overall individual to insure so many should be cost free. They may not be hassle-free, and may require enrollment, completion commitments, or ongoing use of multiple digital apps. You would need to weight the outcome versus the commitment and decide which programs you would like to opt into.

Telemedicine	Wellness Programs	Care Management
<p>Many health plans partner with telemedicine companies to offer instant access to doctors and clinicians as a benefit to their members. The benefits of telemedicine access typically includes a lower or zero dollar cost share for those who choose to call or use the online app.</p> <p>Services such as urgent care triage (do I or don't I go to the doctor now?) or mental health visits from the comfort of your home are just examples of how telemedicine can be used.</p> <p>Each service may require the use of a different application, for example online Physical Therapy may be through CompanyPT, but online Fitness Courses maybe through FitnessCompany.</p>	<p>Many health plans offer wellness programs, like gym member coverage, smoking cessation classes, or pedometer reimbursement. These programs are not typically benefits paid for under health insurance coverage, and instead sit on top of the plan as an added, capped benefit.</p> <p>You should consider that in order to qualify for the benefit - you may have to pay for something upfront, like monthly Weight Watchers memberships or purchasing a FitBit – for which you would then submit for reimbursement. If this is how your benefit is modeled, remember to read the requirements prior to purchasing and keep your receipts.</p>	<p>A care manager is a clinician who assesses patient needs and creates a personalized care plan to improve patient outcomes by coordinating care, removing duplication, and helping people and their families navigate the care continuum. Facilities, such as hospitals and nursing homes also employ care managers. Their role is ensuring the patient is getting the correct care and has a course of action moving forward. Health plan care managers typically work with individuals who have specific diagnoses, but if you feel you need assistance coordinating your care – you should call and ask to speak to someone.</p>

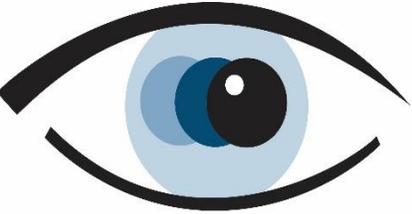


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Appeal Rights

Know your rights to access your plan.

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Appeal Rights

State specific considerations:

1. Your appeal rights timeframe
2. Requirements for first or second level appeals with your plan prior to escalating
3. Medical record and documentation requirements
4. Check with your state to understand if there a cost incurred for any level of appeal

First and Second Level Appeals

- When you receive an outcome from your plan that you disagree with, you should call them and speak to someone about the policies and procedures used to make the decision. Depending on your state, your plan may have to provide this information to you in writing so you may wish to ask for the clinical and benefit related policies.
- You can appeal any decision made by your plan. In some states you can do so verbally, as well as written.
- It is also advisable to talk with your Primary Care Physician. Your PCP and plan should be collaborating on the best possible, most appropriate care.
- First and Second level appeals may be handled by the clinical staff within the health plan or outside agencies hired by the plan to do the review. They may request medical records and other documentation to ensure a thorough review and that the required criteria was met prior to overturning the decision.

Third Party Appeals

- If you are unhappy with the appeal process at your plan, you can file a complaint, grievance, or appeal with your state or local health department – typically within a specific timeframe so know your laws.
- An external appeal is typically conducted by an agency unaffiliated with your plan who works on the state's behalf to ensure plans are following appropriate guidelines for clinical decision making.
- You are not guaranteed an overturned decision.

If the appeal is not successful, call and discuss options with your provider and primary care physician.

Navigating health insurance can be complex and daunting at times. We hope learning the basics has enabled you to ask the right questions in order to understand and utilize your own plan.

Thank you.

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